

FILED APR 28 1947
Registration District No. **1749**

Primary Registration District No. **1002**

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **18 hrs.**
In this community **56 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Blanche Lehmer**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

4. Sex **Fe** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Richard Alfred Lehmer**
6. (c) Age of husband or wife if alive **67** years
7. Birth date of deceased **2 7 1883**
(Month) (Day) (Year)

8. AGE: Years **64** Months **2** Days **5**
If less than one day hr. min.

9. Birthplace **Yates Center Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business
MOTHER FATHER { 12. Name **Theodore Schuler**
13. Birthplace **UNKNOWN Indiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Maude Jones**
15. Birthplace **UNKNOWN UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **R.A. Lehmer**
(b) Address **2810 Madison N.L.M.**
17. (a) **Burial** (b) Date thereof **4-15-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Floral Hills Cemetery**

18. (a) Signature of funeral director **Gates Funeral Home**
(b) Address **1901 Olathe Blvd N.C. Kansas**
19. (a) **4-14-47** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **2810 Madison**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **12**
year **1947** hour **7** minute **23 A.M.**
21. I hereby certify that I attended the deceased from **April 11**, 19**47**, to **April 12**, 19**47**.
that I last saw her alive on **April 12**, 19**47**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebrovascular accident**
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy **See above**
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury
23. Signature **Wm W. Hart** (M. D. or other) **MD**
Address **Med. Dir. Gen'l Hosp.** Date signed **4-12-47**

Dr. J. J. Meyer

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.